DOCUMENT RESUME

ED 347 849 FL 020 617

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TITLE Cultural and Linguistic Imperatives in Public Health Delivery in Developing Countries.
PUB DATE Apr 91
NOTE 15p.; Paper presented at the Annual Eastern Michigan University Conference on Languages and Communication for World Business and the Professions (10th, Ypsilanti, MI, April 3-5, 1991).
PUB TYPE Speeches/Conference Papers (150) -- Viewpoints (Opinion/Position Papers, Essays, etc.) (120)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Attitudes; *Cultural Context; *Developing Nations; Foreign Countries; *Health Promotion; International Communication; *Preventive Medicine; *Public Health; Uncommonly Taught Languages; Vocabulary; Yoruba
IDENTIFIERS *Nigeria

ABSTRACT

Some cultural realities and linguistic considerations are discussed that public health providers can use to make preventive health care delivery more effective and acceptable in several developing countries. The case of the Yoruba people of southwestern Nigeria is used as an example. Two points are addressed: the question of the usefulness of specific aspects of the elements of health in these cultures for mass public health education and treatment, and the theoretical contributions that the ontology of health in an indigenous culture can make to the overall conception of what constitutes health care in both developing and developed countries. The Yoruba culture is discussed in terms of the three types of "ogbon" or wisdom (law, custom/tradition, and taboos) that their ancestors employed to ensure order and longevity. It is suggested that even though English may be used to deliver public health in the urban centers, it may still be necessary to retain the use of original Yoruba terms. It is concluded that health has three dimensions--the political, social, and individual or personal--and that health involves an interwoven or interdependent sense of social and individual responsibility. (LB)

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TITLE: CULTURAL AND LINGUISTIC IMPERATIVES IN PUBLIC HEALTH DELIVERY IN DEVELOPING COUNTRIES

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Introduction.

Medical practitioners, public health care providers, and social workers face unprecedented challenges today. There are new diseases, such as AIDS, which remain incurable while spreading at an alarming rate. There are also increasing social and mental diseases such as alcoholism and child and spouse abuse. Furthermore, childhood diseases once thought to have been eradicated are even beginning to spread again in industrialized countries such as the United States of America.

At the same time, many of these industrialized countries face budgetary constraints which have resulted in dwindling allocations to health. One can only imagine how desperate the situation must be in the largely traditional, pre-industrial and poor countries of the Third World.

A combination of the factors above, among other things, has led health care providers to increasingly emphasize preventive, rather than curative medicine and measures today. Many of today's major killers, such as heart attacks and AIDS, to name but two, are indeed preventable. A recent advertisement from the United States Peace Corps office would seem to underscore the need for preventive health care providers: Of the 600 required health care professionals, 450 are health education, nutrition, and child survival specialists.

The great need notwithstanding, health care practitioners in Third World countries often encounter difficulties in educating and treating local populations in respect of public health. often, this is a consequence of the cultural gap between

traditional medical beliefs and practices and those of the West.

The purpose of this essay is to highlight some cultural realities and linguistic considerations which public health providers can use to make preventive health care delivery more effective and acceptable in several developing countries. This implies a recognition of both cultural and linguistic consideration in public health delivery in these countries. Specifically, the case of the Yoruba people of south-western Nigeria will be used as an example. By understanding the local traditions and, at the same time, building on this foundation, we can both learn and help the process of public health delivery in similar environments and situations.

The focus of this paper is two-fold. First is the question of the usefulness of specific aspects of the elements of health in these cultures for mass public health education and treatment. Second is the theoretical contributions which the ontology of health in an indigenous culture can make to the overall conception of what constitutes health care, both in developing as well as developed countries.

In respect of public health education and treatment, it directs attention to the usefulness of the existing concepts in the construction of health in traditional Yoruba culture to explain the foreign, western concepts of medical practice. Both local and foreign, western-trained medical practitioners often tend to ignore, or, dismiss traditional medical beliefs and practices as, at best, superstitious, or, at the worst, dangerous

habits which require stamping out. Also, based on the analysis of the ontology of health in this illustrative case, the linguistic considerations necessary to express and integrate them into the overall delivery of public health will be discussed. Thereafter, the possible theoretical implications of the ontology of health in Yoruba culture for public health in general will be considered.

The Ontology of Health in Yoruba Culture.

The Yoruba people believe that there are three key **ogbon** -- "wisdom"-- which their ancestors employed to ensure order and longevity (**àjẹpé**). These are:

1. **àṣẹ** --laws;
2. **àṣà** --custom/tradition; and
3. **èèwọ̀** --taboos.

The instrument for ensuring the first, **àṣẹ**, were laws, or the legal system enacted by the relevant governing authority. The consequences for breaking the law varied, ranging from fines to imprisonment, or, even death.

Àṣà, that is, customs or tradition, are established by the relevant social groups in a community, usually one's peer group. The consequence of failing to keep in step with the custom or fashion is ostracism, or, in some cases, being labelled as mad.

The third principle, **èèwọ̀**, or, taboo, is established by the cumulative history of families, communities, and entire sub-groups within the larger ethnic group. The Yoruba say of **èèwọ̀**:

"**Èèwọ̀ ní í ígbèjà ara rẹ̀**" --The taboo is its own enforcer, or, defender. This underscores its importance and the awe in which it is held. Unlike the other two principles, it needs neither a political authority nor a social group to enforce its authority.

From the foregoing, an important observation becomes immediately obvious about **èèwọ̀**. It principally concerns laws that supposedly govern individual health and well-being. That the Yoruba elevated preventive rather than curative medicine to membership of the health "trinity" underscores the wisdom in the age-old belief that prevention is better than cure, a truth captured in the now somewhat hackneyed, but no less accurate, saying that "A stitch in time saves nine".

Since **èèwọ̀** appears to be most central to the issues of public health which concern us here, it is necessary to explain the concept in some detail.

Èèwọ̀ applies to something more than physical health. In the words of Adegboyega Sobande, "**Èyí kéyìí tí kò dára tàbí tí kò wọ̀ láti hù ní ìwà ni wọ́n ń pè ní èèwọ̀**" (23). In other words, anything which is not proper is considered a taboo. Evidently, then, **èèwọ̀** covers the social, political and physical (health) spheres of life. Consider, for example, the fact that one does not use the big toe to pick the nose, an observation which gave rise to the proverb, "**Ìka tó bá tọ́ sí mú la fi í rìn ín**" --One uses the appropriate finger to pick the nose. It will certainly be self-defeating, to say the least, if one were to try and use

the big toe to pick one's nose, if one must. Hence, the **èèwọ̀**, or, taboo, is its own best defender.

Èèwọ̀ may be grouped into six broad categories:

1. Taboos imposed by religion;
2. Taboos imposed by specific diseases --**èèwọ̀ kàn-ńpá tàbí ọ̀ranyàn**; e.g. "Someone who has a cough must not each coconut"; "An epileptic must avoid bean cakes".
3. Taboos imposed by family circumstances or history --**èèwọ̀ abínibí**; e.g. Members of a particular family may be forbidden from eating snails or water yam.
4. Taboos imposed by virtue of cult/lodge membership;
5. Taboos imposed by the requirements for longevity --**èèwọ̀ amẹ́mígùn**; e.g. One cannot eat a snake along with the head; a child must not fall off its mother's back.
6. Taboos which ensure and sustain "good character" and a peaceful existence --**èèwọ̀ amáyégún**; e.g. One cannot marry one's mother or daughter; an older brother may not inherit from the younger (the latter taboo gave rise to the proverb: "Otosi egbon lo njogun aburo, oloriburuku baba ni njogun omo" --only the most wretched of brothers inherits from a younger sibling, just as only the most wretched of fathers inherits from his son.).

The second, third, and the fifth taboos are central to the discussion here. However, when we advance the argument for a holistic view of public health, we would need to consider also the sixth.

Implications for Public Health Education and Preventive Medicine.

First, we need to identify the target populations in which we are interested. Obviously, the highly formally-educated and westernized groups or classes do not need too much help in comprehending western public health practices. The target groups are those at the lowest levels of the social and economic ladders: the illiterate and the semi-literate.

A greater percentage of the population in several Third World countries are illiterate and live in the rural area. They are the ones still closest to the indigenous traditions, often the ones in greatest need of public health, and the ones most ignorant of, and suspicious of western medicine. Most still rely on the expertise of the traditional doctor who is often the only one available to take care of their needs.

But the problems in the provision of public health to these people is not only of their own making. Many health care providers are unwilling to serve in the rural and often inhospitable environments in which these people live. Furthermore, the prevalent attitude among the practitioners who end up there, either willingly, or, unwillingly, is one of disdain and condescension to the population and the indigenous

cultural traditions. The local people are not insensitive to this attitude, which often breeds hostility, thus creating an atmosphere not conducive to education or treatment.

First, western medical health providers need to appreciate the local culture. They need to understand that these people have survived for generations with the aid of some form of health care system, however imperfect. Their minds are not blank slates on which the outsiders can write as they please. More importantly, they need to realize that there are important cultural precepts on which they can build. Therefore, a precondition for success in the practice of public health or any other kind of medicine among these populations is a firm grounding in the ontology of health in the local culture.

The second, and equally important consideration, is that the health care provider must make linguistic accommodations. Several aspects of public health must not only be presented literally in the language of the population, but also interpreted in a cultural sense. Take, for example, immunizations, which may be oral or in the form of vaccinations. The commonly used term for vaccinations in Yoruba-speaking areas is **abéré** --literally "needle". The translation "needle" is not only frightening to many, but it fails to log into what is already locally available. In Yoruba societies, for example, people are used to incisions made in the scalp, the face, or other parts of the body. After these tiny incisions are made with a razor, some form of medicinal preparation, usually in powder form, is rubbed into the

opening, as a prevention against several ailments ranging from the natural to the supernatural. If we discount the absence of live cultures and the wider array of ailments or dangers against which people were traditionally immunized, the principles are similar to those of western medicine. Therefore, a more accessible and acceptable term for vaccinations is the local term **gbẹ́rẹ́**, which refers to the earlier mentioned incisions.

Of course, not all forms of traditional immunization were in the form of incisions. In fact, **gbẹ́rẹ́**, or, incisions, were a part of **àjẹsára**, which is the all inclusive term for immunizations. So, oral does can then be explained using this wider, more inclusive term.

Another area of preventive medicine and treatment in which traditional concepts could be useful concerns medical histories. It is a fact that some illnesses either run in families, or that the probability for them to afflict an individual may be influenced by family history. Ready examples are diabetes and heart disease. Some of these illnesses require strict diets and the avoidance of certain other potentially harmful elements and situations.

It is obvious from the ontology of health in Yoruba that some of these ideas were somewhat evident to earlier generations who coded the results of their observations of family genetic tendencies in the form of **èèwọ̀**, or, taboos. It is more effective then, to explain such problems or diagnoses in terms of the taboos of the third category --**èèwọ̀ abínibí**.

Again, the medical imperative of abstinence from certain kinds of foods as a result of individual medical conditions such as asthma, diabetes, or heart disease is brought home more forcefully to a local patient if explained in terms of the second type of taboo --**èèwọ̀ kàn-ńpá.** This category also covers all types of allergies.

Even though we may use English to deliver public health to those who are partially educated and who populate lower echelons of the civil service in the urban centers, we may still need to retain the use of the original Yoruba terms suggested above. These groups, much like many of their even better-educated and westernized fellows still largely reside in the traditional world. They often visit the traditional medicine men, and , in fact, believe that the traditional medical treatments are frequently more efficacious than modern, western medicine. These are people who would regularly swear on the bible in the court and proceed to lie, but will never swear by the god of thunder and lie.

Nothing can replace the evocative power of the Yoruba terms, **àjẹ́sára** or **èèwọ̀**. Evoking the entire history of the peoples as they do, they carry the knowledge and wisdom of the ancients and command so much authority and compliance. To discard the use of these terms is to lose a most viable resource in public health.

Conclusion.

Besides the improved accessibility and acceptability for public health procedures which an understanding of specific aspects of the construction of health in Yoruba culture may provide, there are some larger, theoretical issues which are raised.

From the foregoing, we may surmise that, in Yoruba ontology, health has three dimensions: the political, the social, and the individual, or, personal. Complying with the dictates of the three principles of **àṣẹ, àṣà,** and **èèwọ̀** bestows health not only on the individual, but on the society at large. **Èèwọ̀ amẹ́mígùn**, for example, focus our attention on the health consequences of social behavior. An **èèwọ̀** in this category, for example, would dictate that you do not get behind the wheels of your car after a few drinks. This is an exhortation to avoid drunk-driving. **Èèwọ̀ amáyégún** commands you to avoid abusing your spouse or children physically or sexually. It also exhorts you to fulfil your responsibilities towards your family and friends.

Similarly, the avoidance of sexual promiscuity, which often exposes one to STDS is an **èèwọ̀** under this category. These are all taboos imposed not just for longevity, but for a peaceful existence. That they are called taboos lends to them greater moral force, which ensures more ready compliance. This is in fact one of the principal reasons for either retaining the original Yoruba word, with its evocative power, or, if we must,

translating them. Thus these larger social health problems of alcoholism, spouse and child abuse and STDs are covered.

The definition of health here also reflects the traditional communalistic basis on the Yoruba society. The Yoruba ontology of health provides a holistic alternative to the fragmented approach which modern societies seem to foster in relation to social and public health. By defining health in political, social, and medical terms, it emphasizes the essential unity of all aspects of a community's existence. A breakdown in any area of the triad can lead to negative consequences on others. The sexual abuse of children, for example, is contrary to the law. But it is often related to alcoholism, which is a flouting of the taboos that have to be obeyed to ensure longevity. STDs often result from flouting the laws of **ètó**, or social health. it then becomes a flouting of the taboos ensuring longevity. Spouse or child abuse breaks the health laws of **ẹtọ́**, and then results in a flouting of the **òfin**.

Finally, this ontology points in the direction of what is required to maintain the overall physical, mental, and social health of a society. Health involves an interwoven or interdependent sense of social and individual responsibility. Traditionally, it is part of one's obligations as a true member of the community, an **omoluwàbí** --the good, or, model, citizen - to obey the law, follow the prevalent custom/tradition, and observe all taboos. Modern societies may well need to be reminded of this holistic definition of what constitutes health, rather

than pursuing a piecemeal approach to social and medical problems that often seem to lead us around in circles.

Works Cited

Sobande, Adegboyega. "Eewọ." Iwe Asa Ibile Yoruba. Ed. Oludare Olajubu. Ibadan: Longman Nigeria Limited, 1978.: 23-29.

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Works Cited

Sobande, Adegboyega. "Èèwọ̀." Ìwé Àṣà Ìbílẹ̀ Yorùbá. Ed. Oludare Olajubu. Ibadan: Longman Nigeria Limited, 1978.: 23-29.